COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

July 19, 2007

ADDENDUM No. 2 TO VENDORS:

Reference Request for Proposal:	**RFP 2007-07**
Dated:	**June 19, 2007**
Due:	**August 16, 2007**

3.9.5 DMAS Remote Access/Email Communications - Replace current language with the following:

For transfer of HIPAA Protected Health Information (PHI) via email communications, DMAS requires that the Contractor use a HIPAA-compliant secure email form of communication. DMAS requires an End to End (Contractor's email system to DMAS Internet email appliances) email communication using Transport Layer Security (TLS) protocol with strong encryption. All email originated by DMAS to the Contractor not using TLS will use the DMAS's Tumbleweed secure email product with appropriate secured restrictions and guidelines applied.

8.3 Binding of Proposal: Change to require six (6) copies of the Technical Proposal

Attachment 1: The Department of Medical Assistance Services response to questions/inquiries as submitted by potential offerors before the July 2, 2007 2:00 pm deadline.

Note: A signed acknowledgment of this addendum (RFP 2007-07 Addendum 2) must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

William D. Sydnor

William D. Sydnor
Contract Management Director

Name of Firm: _____

Signature and Title: _____

Date: _____

Vendor Questions and Answers
RFP #: 2007-07– DRG Audits

Question Number	RFP Section	Question/Comment	DMAS Response
1.	General	Can you identify the incumbent contractor and dollar value of the contract?	This is a new contract an incumbent does not exist.
2.	General	Is there an incumbent performing these services today? If so, who?	See Question #1
3.	General	Please list the organizations that have submitted letters of intent.	Any Offeror who responds to an RFP, upon request shall be afforded the opportunity to inspect proposal records within a reasonable time after the evaluation and negotiation of proposals are complete but prior to award, except in the event the buying agency decides not to accept any of the proposals and to re-solicit.
4.	General	Are there any DRG paid claims (other than those for other reviews) that will be excluded from this audit?	No
5.	1.	Page 8 -What is the basis of the fixed flat fee, per hour of staff basis, or fixed dollar amount per month, or per claim reviewed, or a fixed amount for the entire three year contract, or some other factor?	The contract is fixed flat fee per month to assure DMAS and Contractor will stay within budget guidelines.

6.	1.	Page 8 -The Contractor shall be paid monthly on a contracted fixed flat fee basis. The Department shall not accept contingency based proposals. The Department shall not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to the Contractor based on overpayments identified during the audits." In Items 1 and 5 on page 48, however, the Department clearly assigns evaluation points to project recoveries and the methods of obtaining recoveries, with a portion of the 10% for the general quality and adequacy of the response and 15% (Item 5) specifically for recoveries twice the amount of the contractor's reimbursement. Further, the Department notes that failure to recover twice the cost of the Contractor's services may result in termination of the contract. This arrangement seems to be at least an indirect material inducement based on overpayments identified during the audits, and a significant one. The purpose of the discussion on page 8 seems to intend that the auditor's results will be unbiased by the incentive for financial participation in recovered funds. Placing the entire contract at risk, however, introduces such an incentive. Will the Department consider a performance metric that does not introduce such a bias to be agreed upon with the successful bidder? Additionally, as a result of educational efforts based on audit findings, payment recoveries should decline as claims are submitted more accurately by all hospitals. Does the Department contemplate a metric that would reflect this aspect of the cost-efficiency of the Contractor's performance?	The purpose of the discussion on page 8 is simply to make it clear that this contract will be fixed fee and that the Department expects to recoup at least twice its expenditures. The Department does not believe this will cause an experienced Contractor to become biased. No metric that will allow cost efficiency or a "sentinel effect" will be allowed.
7.	1.1	Page 9 - How can you hold the contractor to generate recoveries twice the proposed contract cost when the amount of overpaid claims is unknown?	The Department believes an experienced DRG Contractor can estimate potential overpayments based on the paid claim volumes. We believe twice the contract amount is a conservative target. Contractors who do not agree are free to adjust their proposals accordingly.

8.	1.1	Page 9 - Is the contractor expected to identify DRG coding errors as well as billing errors (inpatient care billed as outpatient, incorrect patient status code assignment which affects payment, etc.)	Yes, if it affects the DRG assignment or payment.
9.	1.1	Page 9 - What occurs if the Department goal of exceeding at least twice the proposed contract costs per fiscal year is not met by contractor? Recoveries by contractor will depend on the dollars involved for errors identified that are difficult to predict.	The Department believes that an experienced DRG review Contractor will be able to predict and meet expected recoveries. In any case the Department reserves the right to take any contractual action available including cancellation of the contract if fiscal goals are not met.
10.	2.1	Will we have access to the member's claim history that affects the DRG inpatient claims? This would include all other provider claims including a time period prior to, during, and after the inpatient stay.	Yes. The Contractor will only have information related to the inpatient claim.
11.	2.1	Will the Department provide access to the AP-DRG pricers for the specific fiscal years and facilities related to this contract?	The Contractor should have their own access to the AP-DRG grouper system and the Department will provide pricing information.

12.	2.1	Page 10- Virginia Medicaid DRG Hospital Payments Background, the Department explains its methodology for calculating payments to acute hospitals based on the DRG weight and the hospital case rate, "Rates are based on facility cost reports from a base year, and DRG "weights", that adjust the rates for different types of cases, are calculated using patient claims data from the base year. DRG payment equals the DRG weight (the relative cost of the case) multiplied by the hospital's case rate (the statewide average cost of a case, adjusted for the wage costs in the hospital's geographic region, and discounted by the adjustment factor of 78 percent in 2006)." We have obtained the spreadsheets referenced in the RFP from the DMAS website (pr-drg_Psychiatric_hospitals_sfy-2007.xls and pr-drg_Psychiatric_hosp_2008.xls). Are these the correct references for hospital case rates, and are these rates already adjusted for the wage costs in the hospital's geographic region and discounted by the adjustment factor of 78% in 2006? If the rates are not adjusted, will the Department provide the specific factors for each time period to the Contractor so that accurate calculations of overpayments can be made?	This information is in the RFP and was provided by the Department's provider reimbursement staff and is accurate and adjusted.
13.	2.1	Page 10 - Would the contractor be expected to audit claims for discharges prior to 10/01/2004, necessitating the use of Version 14 of AP DRGs?	No
14.	2.1	Page 10 - What is the earliest discharge date to be reviewed by the contractor? Rates are based on facility cost reports from a base year. Version 14 of All Patient Diagnostic Related Groupings (AP DRGs) is used for discharges prior to 10/1/04, Version 21 is used for discharges on or after 10/1/2004 and before 7/1/07 and Version 23 is used for discharges on or after 7/1/07.	Earliest starting date would be 7/1/05; however the Department is open to suggestions.
15.	2.1	What was the total dollar amount of overpayment that was assessed in 2006 based upon all audits performed? In addition to the 5% random review.	Approximately 1 million dollars in overpayments were retracted each year based on random DRG reviews. Data for 2006 is not available.

16.	2.1	What was the Fee for Service inpatient claims dollars and volume of claims for out-of-state hospitals for CY2006?	See Attachment VI in CY 2006, 1397 claims representing $5,696,000. However, these out of state claims are paid on negotiated rates and not on DRG basis. For the purpose of the RFP several larger volume out of state facilities in adjacent states are listed in the facility list and are billing the Department as per their agreement on a DRG basis.
17.	2.1	Page 10 - The RFP states that the department is currently reviewing DRG claims and that approximately 5% are reviewed on a random basis. Please clarify if the $1 million retracted each year is for DRG coding errors only or includes other billing errors.	This was for DRG coding errors only.
18.	2.1	Can the department provide a report with aggregate data of previous DRG audit findings?	No. Not at this time.
19.	2.1	Page 10 - Indicates that the Department currently reviews approximately 5 percent of claims annually. Does the Department anticipate that it will continue internal DRG reviews concurrently with the selected vendor?	The Department reserves the right to conduct DRG reviews concurrently. However at this time we do not anticipate any significant internal review activity during the length of the contract.
20.	2.1	Page 10 - Are the claims that were previously audited by the state (5% random selection) be identified in a data file?	Yes. The Department does not wish any duplications or overlaps in reviews.
21.	2.1	Page 10 -You state that currently you reviewed 5% of the DRG claims and retracted $1 million each year, were those recoveries based on DRG changes only or for other reasons, i.e. medical necessity, utilization review, billing errors, processing errors)? If so, please delineate the distribution by error type in dollars and number.	DRG changes only.
22.	2.1	Page 10 - After contract award, is it the Department's intent to continue to perform a 5% random review of all DRG paid claims?	No

23.	2.1	Will the Contractor be expected to take action on any changes to diagnosis/procedure codes or other data elements on the claim that do not result in the assignment of a lower weighted DRG?	No
24.	2.1	Is there a data element on the hospital claim to indicate if the recipient is enrolled in the managed care program, or will the Contractor have to match claims data to provider and recipient eligibility data to make this determination?	Yes, there is a data element on the claim file indicating managed care. But the Contractor as an extra measure may want to do a separate match.
25.	2.1	Does the hospital claim record include the patient medical record number and/or patient account number in addition to the Medicaid number?	For the vast majority of claim records the patient's medical record is on the claim file.
26.	2.1	Will the Contractor be able to identify claims that have been adjusted and/or denied so that Contractor-identified overpayments will be accurate? Does the claim include a data element that indicates if the reimbursement has been adjusted, and why?	Yes, the Contractor will receive a full file including adjustments. Yes, there are file elements for adjustments and reason codes.
27.	2.1	Does the Contractor have any responsibility for review of outlier dates or amounts?	Yes as it relates to the entire admission.
28.	2.4	Page 11 - Is it required to contact recipients to verify services rendered?	The Contractor should propose if they believe it will be necessary to contact recipients. If so, their procedure for contacting should be detailed in their response.
29.	2.4	(Definitions) includes the term "Global Analysis" at the top of page 13, but there is no mention of this term elsewhere in the RFP. Is a "global analysis" required under this RFP? If so, is it the same or different from the "global analysis" that was referred to in RFP 2007-04 and RFP 2007-05? Please explain.	**This should have been deleted. The targeted DRG requirement is in lieu of the global analysis that was in RFP 2007-04 and 05.**

30.	3	Page 14 -This paragraph states that if a recovery action leads to any appeal proceedings, the contractor shall assist DMAS by providing record review, preparation of appeal summaries, testimony, and appearance and testimony at depositions and hearings. Do the contractor's obligations to provide appeal assistance and recovery assistance end upon termination of the contract, even as to overpayments identified before termination of the contract?	Yes. The Contractor is responsible for appeals and reconsiderations that were generated by the Contractor activities.
31.	3	If the latter, how is the contractor compensated for providing this assistance after the contract has terminated? This same issue arises under Section 3.1 subparagraph 3, fourth bullet item on page 17, Section 3.5 on page 20-21, and Section 3.6 subparagraph P on page 23.	These activities are part of the contract terms and scope of work and should be considered when developing timelines and assignments over the three year period.
32.	3.1	Page 15 - Indicates that a minimum number of audits is required. However, a number is not provided. Could the Department provide the minimum number of audits – or should the vendor propose a minimum number such that the total number of claims audited will not exceed 10 percent?	**Clarification on number of reviews and sample size:** **Year 1- 5%, Year 2 – 7%, and Year 3 -10%. The Contractor should propose audit methodology that will place DMAS at the leading edge of health care auditing. Proposers should not assume that the Department wishes to duplicate its current auditing practices.**
33.	3.1	Page 16 - The RFP states that the audit sample cannot exceed 10% of total paid DRG claims and the offeror shall propose the breakdown by review type. What is the percentage of total claims in CY 2006 that were prior authorized?	See Question #32. Also at this time, all hospital admissions must be pre-authorized except for maternity and deliveries.

34.	3.1	On page 16 the RFP indicates that the mix of sample methodologies is expected to change over the course of the contract. If the sample for targeted DRGs is 7% - 10% in years two and three of the contract, will this sample be the entire selection, or will the overall sample increase so that the three types of selections on page 15 are still used?	The sample size increases, but the three types of selections remain the same.
35.	3.1	Can more specifics be provided on the types of claims that require preauthorization? (i.e. types of admissions, procedures).	Currently all hospital admissions except maternity and deliveries are pre-authorized. If this changes then the Contractor will be notified.
36.	3.1	For the purposes of pricing the 3 year contract period, should the contractor limit sample size to not exceed 10% of total paid DRG claims for each year of the contract or use the projected percentage of increase (7% targeted reviews in year 2 and 10% in year three of the contract)?	For the purpose of pricing the Contractor should provide a price using the sample increase for each year. The Department has the option based on budget to maintain the same percentage as previous sample year.
37.	3.1	Page 17 - Please verify that there are three levels of review (preliminary audit, final audit, and appeal).	After the preliminary audit the contractor will send the report to the Department for review. After review by the Department, the Contractor will send the final audit result letter to the facility. The facility will have a period where they can request reconsideration and if they disagree with the reconsideration response, the facility can appeal.
38.	3.1	Please confirm that each facility receives a preliminary and final audit report? In addition to the audit reports, does each facility receive individual letters for records identified with overpayments? If individual letters are to be issued, are these letters to be issued simultaneously with the preliminary and final audit report?	See Question #37. Each facility receives final audit letter for all records identified with overpayments. Individual recipients must be identified in a separate spreadsheet.

39.	3.1	Page 15 -What is an “error matrix”? Please describe in detail the content and the format for the error matrix.	This is a spreadsheet to identify errors. The Contractor must propose details.
40.	3.1	Page 16 - States that “the total of the three review types cannot exceed 10% of total paid DRG claims”, but the following paragraph states “The Department is anticipating an increase to 7% targeted reviews in year two . . . and an increase to 10% targeted reviews in year three of the contract”, does this mean that the first year total is limited to 10% but then year two is limited to 7%, or does this mean something else? Please clarify.	See Question #32
41.	3.1.3	Page 16 -What is meant by “analyze and rank the DRG claims in question”?	The Contractor should use past experiences to determine which DRG claims are most egregious or “rank” priority review.
42.	3.1	Page 17 - Please provide clarification regarding the number of days hospitals are given to provide records requested for preliminary review.	This will be determined by the Contractor with consultation from the Department.
43.	3.1	Please provide clarification regarding the number of days hospitals have to provide additional information in response to a preliminary audit report.	See Question #42
44.	3.1	What is the Department’s current appeal / reconsideration / overturn rate for claims that identified as overpayment recoveries? How many appeals proceedings occur annually that progressed to hearings?	As there is no incumbent the data is not available. Contractor should base appeal and reconsiderations estimates on past experience providing DRG similar auditing services.

45.	3.1 2.1	(General Audit Requirements and Scope), item 2, bullet 2, on page 15, states that "DMAS specifies that the Contractor shall perform the following minimum number of audits per 12 month period." However, the RFP does not then specify a minimum number of audits. Instead, it states that the listed types of reviews cannot exceed 10% of the total paid DRG claims. Earlier, on page 10 of the RFP, Section 2.1 indicates that approximately 5% of the claims are reviewed on a random basis. At the top of page 16, the RFP states that the Department is anticipating an increase to 7% targeted reviews in Year 2 of the contract and an increase to 10% targeted reviews in year 3. What is the minimum number of audits expected during year 1?	See Question #32. In its effort to improve audit processes, the Department believes Contractors should propose the most efficient and cost effective audit volume.
46.	3.1	If the hospital does not provide requested records for review within requested timeframes, may the contractor deny the entire DRG payment as a technical denial and identify the DRG payment amount as an overpayment in its audit report?	Yes, however historically providers have been allowed to produce missing documentation during appeal. Any overpayments overturned at appeal will not be credited to the Contractors fiscal goals.
47.	3.1	The RFP states that DMAS cannot predict the number of appeals that shall be filed or number of hours requiring contractor services. In CY 2006, DMAS conducted a 5% random sample and recouped $1 million in overpayments. Can data be provided regarding the number of cases with payment errors and number of cases appealed?	As the Department is not seeking to replicate its effort or outcomes, the Contractors should base past experience in predicting payment errors and case appeals.
48.	3.1	Can data be provided for CY 2006 identifying number of informal versus formal appeals that were conducted related to DRG audit findings?	No. See Question #47
49.	3.1	Page 15 - Are there any circumstances that the Department will require on-site reviews?	Yes
50.	3.1	Page 16 - Will the Department provide the name of the POC "specific person" at each facility to direct the request for medical records?	No, the Contractor will be responsible for all contact with the facility.

51.	3.1	Page 16- The RFP indicates that the mix of sample methodologies is expected to change over the course of the contract. If the sample for targeted DRGs is 7% - 10% in years two and three of the contract, will this sample be the entire selection, or will the overall sample increase so that the three types of selections on page 15 are still used?	See Question #32 and #36.
52.	3.1	Can the Department provide a brief discussion of the internal methodology previously used for requesting and reviewing medical records? For example: Were there specific medical records or other points of contact for off-site medical record requests and on-site audits? What period of prior notice did the Department allow for on-site audits? Did the Department indicate a timeframe for submitting medical records to be reviewed? Were second notices issued for off-site medical record requests? How frequently did hospitals fail to submit records for either on-site or off-site review and all associated payments were retracted? What approximate percentage of claims resulted in the identification of an error? What timeframe was allowed for submission of additional information in response to a preliminary audit finding? What percentage of audits resulted in a reconsideration? What percentage of audits went to the appeal level? Approximately what percentage of audited claims required peer review	No. Contractors should utilize its past audit experience to determine methodology for requesting and reviewing medical records.

53.	3.1.3	Page 17 - A preliminary audit report is required within a specified period of time by DMAS after receipt of records from the facility. Is the intention of DMAS that records would be received within 30 days from the facility? What is included in the preliminary audit report?	See Question #37 and Question #42
54.	3.2	Page 19 - "The Department reserves the right to provide directives based on policy needs that may not prove to be fiscally productive", how much time or dollars should the contract include in its cost proposal to cover these Department directives? Please describe possible scenarios when this might occur.	**CLARIFICATION: Please omit this sentence.**
55.	3.2	Is *Coding Clinic* considered the official coding guideline for VA Medicaid?	Yes, our hospitals utilize it in conjunction with our provider manual and memos.
56.	3.2	Page 18 - What is the estimated percentage of cases that would be excluded from the Contractor's review? May the Contractor assume that claims currently under review, or previously reviewed will excluded (or identified) from the data transfer prior to being sent to the Contractor?	See Question #20 Yes- Identified
57.	3.2	Page 18 - Indicates that services will include "assessing the accuracy of the DRG assignment of all fee-for-service inpatient hospital." In the event that overpayments are identified that are caused by VAMMIS processing or programming logic, or for any cause other than the provider, will these claims be subject to recoupment from providers as part of this initiative?	No. However, the Contractors are to inform the Department of any errors they detect in VAMMIS or claims as part of their reviews.
58.	3.2.1	Page 18 - It states that "the data-mining criteria will be submitted to the Department for approval prior to commencing data review." Does this only refer to data-mining criteria developed to incorporate the Department's specific benefit plans and reimbursement policies?	Yes
59.	3.2.2	Page 18 - How will duplicative cases be excluded? What kind of reviews is the Department doing that would duplicate "DRG audits"? What was the monetary value of these reviews?	See Question # 20

60.	3.2.2	Page 18- 3.2.2 What types of fee-for-service claims are currently being, or have been previously, reviewed by the Department and will be excluded from this contract? Please provide greater detail on the cases that have been previously reviewed by the Department?	See Question #20
61.	3.3	Page 20 -The paragraph refers to the Contractor's availability to discuss repayment plans with facilities. Please describe in detail the role of the Contractor.	**CLARIFICATION: The contractor will not have a role in repayment plans.**
62.	3.4	The RFP states that the contractor will issue the first letter that identifies errors, documents references, rules, etc., and offers reconsideration. The first letter must offer the hospital an opportunity to request a reconsideration review. Please verify that the demand letter is sent after the hospital has requested a reconsideration review and that the demand letter contains language informing the parties of further appeals right (i.e. informal and formal proceedings).	Yes
63.	3.4	For CY 2006, can DMAS provide data on the number/percent of cases with preliminary DRG errors identified as overpayment and the number/percent of cases reconsidered based on additional information provided by the hospital?	See Question # 47
64.	3.4	What requirements are necessary in the reconsideration process? For example, if the case involved physician review, must the case be reviewed by a different physician that was not involved in the preliminary review?	Please review 12 VAC 30-20-540 for informal appeal information and 12 VAC 30-20-500-560 for appeal information. The Contractor should use its past experience to determine the requirements.
65.	3.4	What is the time limit for the hospital to respond to the reconsideration with additional pertinent documentation before further action is taken?	The Contractor, based on past experience, will propose the time limit for the hospitals to respond to reconsiderations with the Department's approval.

66.	3.4	If the hospital decides to appeal, is there a required time period for each level in the appeal process in addition to the reconsideration process? Can the department provide the template letter that is currently used?	See Question #64 No, the Contractor should give the Department examples of template letters.
67.	3.4	Please clarify whether the scope of services is for identification of overpayments only, or whether the work scope may also include some recovery tasks. The following sections in the RFP seem to indicate that some recovery work may be required: ▪ RFP cover letter: "Most [emphasis added] costs associated with pursuing the recovery of overpayments shall be the responsibility of the Department." ▪ Section 9.2, Proposal Evaluation Criteria, p. 48: Item 5 indicates that 15% of the proposal evaluation will be based on "the projected recoveries and how the Contractor shall achieve the recoveries by the end of each State fiscal year of at least twice its contracted costs." ▪ Attachment III, Cost Proposal, page 73: Offerors must present "proposed recovery" amount at the top of the form.	The Contractor will identify the overpayments and proposed recovery and the Department will be responsible for recouping the overpayments.

68.	3.4	In Section 3.4 on page 20, the RFP discusses appeal procedures. This section seems to indicate that the initial letter to providers is the final audit determination and that hospitals then have reconsideration rights. Please clarify if the term "reconsideration" refers to the review of information submitted by the hospital in response to a preliminary audit finding, with appeals conducted as reviews after the final audit finding has been distributed to hospitals.	Yes
69.	3.5	Page 21 -What is the Department's historical experience for informal appeals that is how many retracted overpayments have been appealed during the last three years?	Data is not available.
70.	3.5	Page 21 -What is the Department's historical experience for formal appeals that is how many retracted overpayments have been appealed during the last three years?	See Question # 69
71.	3.6	The RFP states that the contractor shall conduct an exit interview with the audited facility at the conclusion of the review to discuss audit findings and proposed adjustments. Please clarify if the exit conference is to be conducted after the preliminary audit or after the final audit.	The Contractor should use its past experience to recommend to the Department when the interview should take place.
72.	3.6	Some employees are out-of-state, can DMAS on-site training and orientation programs be done at Contractor location at Contractor's expense?	During the implementation phase, the Department and the Contractor will assess the need for SME training; however it can be anticipated that some on site training will be needed.
73.	3.6.C	Page 21 - In this section reference is made to the exit interview with the audited facility at the conclusion of the review. This infers that all audits will be done by facility. Will DMAS accept any other audit methodology that meets the needs of providers as well as creates efficiency and timeliness in the performance of responsibilities?	Yes

74.	3.6.G	Page 22 - If your review was conducted in the last month of the contractual year, how will the 30-days reconsideration period be possible?	See Question #30
75.	3.8	Page 24 - Please clarify ‘facility classes’ that may be included in	**CLARIFICATION: Change facility classes to scope of work.**
76.	3.8	Page 24 - “Department determines that additional facility classes should be subject to auditing”, what is meant by “additional facility classes”?	See Question #75

77.	3.9.1	How many years of claims history will we receive at the time of implementation? References: Page 9 paragraph 1.1 bullet point 9 - Although we will not be using extrapolation as a recovery method, this implies that we will be capturing claims history. Page 10 section 2.1 paragraph 2 - This question refers back to #3 above. The AP-DRG versions are being referenced by effective years. This reference leads me to believe that there will be history data greater than or equal to three (3) years. *NOTE discharge dates:* *Prior to 10-1-04 = version 14* *10-1-04 thru 6-30-07 = version 21* *7-1-07 and after = version 23* Page 18 section 3.2.2 – ….This paragraph states that Contactor will be "Assessing……all fee-for-service inpatient hospital claims". This does not state a time period. Page 14 section 14 - DMAS in consultation with the Contractor shall determine the time frame to be audited. This may refer to a specific case being audited or the project as a whole. Page 26 section 3.9.2.2 – Claims and encounter data is pulled from state quarterly.	The Department will provider at least two years of data with quarterly updates. If the Contractor desires additional years or a different updated schedule it should be included in its proposal.
78.	3.9.1	Page 25 - To what extent will the data need to be cleaned?	The data formats and data elements will be finalized after contract award during the implementation period. The data will be in a format already 'cleaned' and required for the contractor's use.

79.	3.9.2	Page 25 - Will the data formats provided at the time of issuance of the Department's response to written comments include field length and record size information?	The data elements were provided as Addendum 1 on 6/26/07. Any data formats and date elements questions will be finalized after contract award during the implementation period.
80.	3.9.2	Because data is totally refreshed each time, will the data be uniquely identified?	The file names associated with each file will be unique per associated time period.
81.	3.9.2	What is the expected or estimated number of records in the provider data file?	Estimated to be 50,000 – 55,000 providers/records.
82.	3.9.2	Page 26 -Although section 3.9.2 states that the formats will be provided at the time of written comments, will this include a requirement for a trading partner agreement?	The data formats and data elements will be finalized after contract award during the implementation period. The trading partner agreement also will be done with our fiscal agent after contract award during the implementation period.
83.	3.9.2	What is the expected or estimated number of records in the recipient data file?	Estimated to be 300,000 – 500,000 recipients/records.
84.	3.9.2.1 3.9.2.2	Page 26 -May the Contractor assume that authorized claims have undergone recipient eligibility and provider eligibility prior to being authorized, and that those elements of review are not a requirement for this RFP?	Yes
85.	3.9.2.1	Page 26 - Is this format compatible for usage with any database management system?	All files produced will be flat, fixed length files, generated from an IBM Type mainframe in EBCDIIC format. The Contractor must ensure that these types of files can be loaded in their database.
86.	3.9.2.3	An initial data load is to be completed during the implementation period, and all subsequent processing would supplement this initial data load (not complete file replacement). *Question: Will the contractor be required to apply adjustments to the data already received, or will the data be provided in "final action paid claims" format?*	Adjustments/Voids could be received in subsequent claims files when associated with original claims in previous claims files. Yes, the Contractor would be required to apply those adjustments.

87.	3.9.3	The Contractor shall 'pull' all data as described…from the VAMMIS fiscal agent…by secure electronic file transfer protocol. The Contractor shall describe in detail their secure FTP connectivity…" Section 3.9.4: "The Contractor is to access the FHSC Secure File Transfer Server over the Internet. This process supports the FTPS…for secure communications between the Contractor and the server. An area on the server will be created for the Contractor to GET files". *Question: Are Sections 3.9.3 and 3.9.4 referring to the same process and location from which to "pull" data?*	Section 3.9.4 does not contain any language related to the question. Section 3.9.4 is not associated with FTP and how the data files are obtained. DMAS no longer requires access to the contractor's database and processing system, therefore, this item of Section 3.9.4 does not need to be addressed in the proposer's response.

88.	3.9.4	Section 3.9.4 states DMAS "owns the database". Does this section actually mean that DMAS owns the data? References: Page 27 Section 3.9.4 – The database shall be the property of DMAS. Paragraph 3 refers to the database as the "Contractor's database". Contractor comments: Contractor licenses Microsoft SQL Server database management system (DBMS) technology for the purposes of offering our services. The specific system architecture, database design/schema, and instance of the database used to store customer data is the proprietary property of Contactor. The customer does not own the data store itself, the database management system (Microsoft SQL Server), any licensed copies of the DBMS, nor the design, implementation and/or direct maintenance of these systems. Only the data itself is the property of the DMAS.	Paragraph 3 states that 'the MMIS specific audit data stored in the Contractor's database shall be the property of the Department'. The intention of this sentence is to ensure the data is the property of the Department and the database is not the property of the Department.
89.	3.9.4	Page 27 - "Although the Contractor will maintain the database and processing system at their facility, DMAS shall have access to the database and the MMIS specific audit data stored in the Contractor's database shall be the property of the Department", does this mean that any of the Contractor's proprietary software employed to analyze the claims data becomes property of the Department?	See Question #88

90.	3.9.4	the Contractor must provide DMAS with remote access (read-only) to the Contractor's computer system with respect to all Virginia Medical Assistance Programs audit requirements/activities…the Contractor shall maintain a HIPAA compliant database". "…DMAS shall have access to the database and the MMIS specific audit data stored in the Contractor's database shall be the property of the Department". *Questions: 1) Will DMAS personnel perform queries/manipulating the database themselves, or will they access data based on queries performed by the Contractor? 2) If DMAS personnel need 'access' to the underlying database itself, a secure connection will be required either via a secure private line or via a virtual private network. Will DMAS be prepared to install VPN clients on appropriate machines to access the database?*	**CLARIFICATION: DMAS no longer requires access to the Contractor's database and processing system, therefore, this item of Section 3.9.4 does not need to be addressed in the proposer's response.**
91.	3.9.5	For transfer of HIPAA Protected Health Information (PHI) via email communications, DMAS requires that the Contractor use a HIPAA-compliant secure email form of communication." *Question: Section 3.9.3 comments that PGP is supported by FHSC. Is PGP available for all DMAS personnel needing PHI via email?*	No
92.	3.9.8	Can more details be provided regarding the contractor's processing system in terms of what meets or does not meet functional and informational requirements?	This section is to confirm that DMAS will be monitoring and reviewing the testing and implementation of the Contractor's processing system prior to the implementation date to ensure the system implemented meets all of DMAS's requirements included in the RFP and subsequent addendums. The testing and requirements review will be done with assistance from the Contractor.

93.	3.10	Is the Project Manager expected to attend face-to-face meetings with the Department on a weekly basis or could this be done by teleconference?	No. This can be done by teleconference.
94.	3.10	The RFP states that auditors and data analysts may be located outside of the state. Would it be acceptable to the department for the project manager to be located out-of-state as long as weekly teleconferences were conducted to discuss the status of audits and issues identified?	Yes. However, a periodic face to face meeting may be required.
95.	3.10	If the project manager must be out-of-state, is there any requirement that the contractor must have an office in the state?	No
96.	3.10	This paragraph states that a "qualified medical physician… shall be available for medical necessity determinations." Is the contractor expected to determine medical necessity of inpatient admissions?	Yes as it relates to DRG assignment or a question of a short stay versus and inpatient admission.
97.	3.10	Are there any rules/regulations that must be followed regarding what types of cases must be referred for physician review?	No. The Contractor should utilize its past experience.
98.	3.10	Does the department desire only one qualified medical physician (licensed in Virginia) to be available for assistance with case review decision? Is there any requirement to have matched specialty review? Please clarify what is meant by "peer to peer counseling as needed."	No. The Contractor should propose using their experience in health care services.

99.	3.10	Can the department provide the number of individual DRG case reviews that were performed by the department in CY 2006 and the number of cases that required physician review? Of these cases, how many appeal hearings (both informal and formal) required physician reviewer participation?	No
100.	3.10	Please describe the retail practice requirements for qualified reviewers.	**CLARIFICATION: Substitute hospital medical record coding for retail practice.**
101.	3.10	Does the Commonwealth require all medical necessity denials to be made by physicians licensed in the Commonwealth of Virginia? Will the availability of physicians licensed in the Commonwealth to discuss these cases, if necessary, be acceptable and sufficient?	See Question #98. Yes
102.	3.12	Page 33- Has DMAS conducted similar projects that require the fiscal agent to provide the claims/facility/client data? Were the costs quantified? If so, please provide dollars and hours. How are the costs for data retrieval determined? What is the cost for data retrieval? Is there a specified hourly rate? Or is it another method? If so, please provide detailed method and associated cost.	The provision of data and extracts will be provided to the Contractor at no charge.
103.	3.12	Page 32 - What is the "Operational Readiness Assessment Plan"? Please describe in detail the content and format.	The Contractor should be familiar with this type of plan from its past audit experience.
104.	4.1	Page 35 - This paragraph requires that "recoupment" amounts collected in prior months be included in monthly summary reports. The term "recovery' is defined on page 13 of the RFP. The term "recoupment" does not appear to be defined. The RFP states that DMAS will conduct Recovery. Thus, DMAS, not the contractor, would know what amounts had been recouped in prior months. Request clarification of what is required with respect to "Recoupment" amounts in Section 4.1, subparagraph 2.f.	The Contractor will submit on a monthly basis to the Department the amount identified for recoupment. The Department will handle all recovery efforts.

105.	4.1	(Reporting Schedule), item 4, on page 36 requires the Contractor to provide additional ad hoc reports at no additional expense. What is the expected general range of ad hoc reports that will be required on average each month?	The expected range will depend on the circumstances and will be discussed with the Contractor.
106.	4.1 2. d.	Page 35 - Please clarify what information you are requesting when you ask for the "means by which overpayments were identified".	The Contractor should identify reference tools that were used to identify overpayments.(ex. CFR coding guidelines)
107.	4.1 2. f.	Page 35 - How will the contractor know what recoupment amounts have been collected since the Department is doing the recoupment?	See Question #104
108.	5	May the Contractor assume these cases will be excluded from the database prior to the data pull? Will the Department provide points of contract for the Program Integrity Division review activities and other contractors who perform reviews of DRG claims?	Yes. There are no other Contractors who perform reviews of DRG claims. The Department will assign a Contract Monitor to the project.
109.	6	Page 39-40- Please clarify DMAS responsibility to approve all letters that the Contractor sends to facilities, i.e., Does this mean each individual case letter versus the letter templates?	The Department will review the letter templates.
110.	*8.2*	Please identify the percentage of small business participation?	Refer to the RFP §9.2 on page 48 for the Evaluation Criteria Weight for Small Business Participation
111.	*8.2*	Page 41 - Section 8.2 specifies a minimum of three references, but also says that Offerors "must include references from all state governments, Medicaid business in particular, for which the Offeror is currently under contract with for similar services." In contrast, Section 3.7 (Experience) requires 4 references—but also states that Offerors must "list all relevant experience . . . in the last three years." 2.a. How many references are required; is the minimum three references (per Section 8.2), four references (per Section 3.7), or other? 2.b. What does the Department consider to be "similar services" or "relevant experience"?	**CLARIFICATION: Use section 8.2 for references.** **The Department is seeking a Contractor with Medicaid DRG audit/review experience.**

112.	*8.2*	*(Critical Elements of the Technical Proposal, p. 41) and Section 9.1 (Minimum Requirements, p. 47)* – These RFP sections specify that Offerors must respond to each requirement in RFP Sections 3 (Requirements) and 4 (Reporting and Delivery Requirements). However, it also appears that RFP Section 5 (Controls) requires a response. Please clarify whether or not Offerors must respond to RFP Section 5.	Yes
113.	8.2	Page 41 - Please clarify if the requirements identified in Section 5 are / are not to be included as part of the Technical proposal. Does the Department have specific contracts with any of the facilities?	Yes- include in the proposal
114.	8.3	The RFP requires that 12- point font shall be used in the proposal. May we use a smaller (but clearly legible) font size in charts and graphics?	Yes
115.	8.3	We understand that the CD copy of the Technical Proposal must be in MS Word format, and the CD copy of the Cost Proposal must be in MS Excel format. However, may we provide electronic copies of signed documents (e.g., RFP cover page and addenda cover pages) in Adobe Acrobat (PDF) format?	Yes
116.	8.3	For ease of shipping, may we place the Cost Proposal (separately sealed, and clearly marked as the Cost Proposal) inside the larger sealed container in which we send the Technical Proposal?	Yes

117.	*8.6*	Page 44 - Requirement 1a) states that Offerors "and any related entities must identify any client relationships, contracts, or agreements they have with any State or local government entity that is a Medicaid and/or title XXI State Child Health Insurance Program facility or Contractor and the general circumstances of the contract or agreement." Does this requirement pertain to disclosure of relationships with providers that could conceivably be audited under the DMAS DRG review contract? If not, please clarify the required disclosures	Yes
118.	8.7	Page 45 - Is page 1, which is titled REQUEST FOR PROPOSALS RFP 2007-07, considered to be the "cover page of this RFP" which is to be signed by the Offeror?	Page 2 of the RFP must be completed and executed and included with the Offerors response.
119.	11.7.3	Page 59 - Are there funds available to cover the Contractor's monthly invoicing after implementation?	This project has an approved budget.
120.	11.20	Page 64 - Does this mean that any of the Contractor's proprietary software employed to analyze the claims data becomes property of the Department?	No, the software does not become the property of the Department; however the data must be delivered in an easily accessible format approved by the Department and becomes the property of the Department.
121.	11.20	Page 65 - What is meant by "ownership of specifically identified intellectual property"?	All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.
122.	11.22	Is this solicitation for a term contract? Do requirements for the eVA Catalog apply to this procurement?	The resulting contract will be for a period of three years with provisions for three one year renewals. eVA Catalog do not apply.

123.	Attachment II	Page 68 - The definition of "Small Business" in Attachment II of the RFP indicates that "small business" means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of $10 million or less averaged over the previous three years. Please verify that a business that has less than 250 employees but exceeds the average annual gross receipts of $10 million or less averaged over the previous three years qualifies under the "small business" definition.	Yes, the business MUST be certified by the Department of Minority Business Enterprise at the time of proposal submission. www.dmbe.virginia.gov
124.	Attachment II	If the contractor meets the definition of "small business" as described in Attachment II, does the contractor automatically satisfy the requirements specified in the small business subcontracting plan and receive the maximum number of evaluation points (20% proposed weight) listed in the evaluation criteria table on page 48 of the RFP?	See Question #123
125.	Attachment III	Does DMAS require Cost Proposal content beyond a completed version of Attachment III?	No
126.	Attachment IV	Page 76 - Are there any scenarios where a hospital would receive separate DRG payments for readmissions within 5 days?	Theoretically No
127.	Attachment IV	Please clarify the DMAS Provider Class Types (PCTs)?	Provider Class Types are a description of different types of providers that provide services to the Department.
128.	Attachment IV	Will the Contractor be verifying coordination of benefit payments (COB) with primary carriers during the audit process?	No. But if the Contractor suspects this type of occurrence the Department is to be notified.
129.	Attachment IV	Will the Contractor be validating the adjudication of the claim based on benefit coverage and limitations?	No

130.	Attachment IV bullet point 4	Will Contractor be verifying recoveries for third party liability claims such as accidents, worker's compensation, and other negligent acts?	See Question #128
131.	Attachment V	Will the Department provide the Contractor the AP_DRG List with Weights for FY 2006, 2007, and beyond?	Refer to http://www.dmas.virginia.gov/pr-hospital_rates.htm.